

The Matrix Evidence Tables

PSYCHOSOCIAL INTERVENTIONS FOR PEOPLE WITH PERSISTENT PHYSICAL SYMPTOMS

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INTRODUCTION

INTRODUCTION

Persistent Physical Symptoms, refers to health problems that last a year or longer, impact on a person's life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category. Common examples include diabetes, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease (COPD).

Around 2 million people in Scotland have at least one such condition, and one in four adults over 16 years reported some form of long term illness, health problem or disability, and one in five have chronic pain. These conditions become more common with age. By the age of 65, nearly two-thirds of people will have developed Persistent Physical Symptoms, however, more people under the age of 65 years in Scotland have multiple conditions.

The human costs and the economic burden of Persistent Physical Symptoms for health and social care are profound. Sixty per cent of all deaths are attributable to these conditions and they account for 80% of all GP consultations. Research evidence shows that people with these conditions are two to three times more likely to experience mental health problems than the general population. There is strong evidence for an association with cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders. There is also evidence for higher than usual levels of psychological problems among people with other conditions, including asthma, arthritis, cancer and HIV/Aids (Chapman et al 2005; Sederer et al 2006). In addition to the relationship with diagnosable mental health problems, there is an independent association between physical illness and emotional distress (Delahanty et al 2007).

THE HUMAN COSTS AND THE ECONOMIC
BURDEN OF PERSISTENT PHYSICAL
SYMPTOMS FOR HEALTH AND SOCIAL CARE
ARE PROFOUND

Chapman, D. P., Perry, G. S., & Strine, T. W. [2005]. The vital link between chronic disease and depressive disorders. *Preventing Chronic Disease*, 2[1]. Retrieved from http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm.

Sederer, L. I., Silver, L., McVeigh, K. H., & Levy, J. [2006]. Integrating care for medical and mental illness. *Preventing Chronic Disease*, 3[2]. Retrieved from HYPERLINK "http://www.cdc.gov/pcd/issues/2006/apr/05_0214.htm" http://www.cdc.gov/pcd/issues/2006/apr/05_0214.htm.

Delahanty, L. M., Grant, R. W., Wittenberg, E., Bosch, J. L., Wexler, D. J., Cagliero, E., & Meigs, J. B. [2007]. Association of diabetes-related emotional distress with diabetes treatment in primary care patients with type 2 diabetes. *Diabetic Medicine*, 24[1], 48-54.

Recommendations for psychosocial interventions for people with a Persistent Physical Symptoms are summarised in the following tables, (for evidence for Stroke and Parkinson's Disease please refer to the **Neurological Disorders** tables), providing guidance for healthcare professionals involved in their care and treatment. Recommendations for interventions are presented per physical and/or mental health outcome and per physical health problem and/or mental health problem severity level; in some instances the same evidence may be referenced for both the physical health outcome and mental health outcome sections.

Overarching recommendation for healthcare professionals

NICE Guideline CG911 'Depression in adults with a Chronic Physical Health Problem' recommends that practitioners should be aware of the elevated risk of common mental health disorders and co-morbid psychological difficulties, particularly depression, in people with a Chronic Health Problem, underlying the guidance on effective case identification and recognition, and on risk assessment and monitoring for this patient group.

Where low or high intensity psychosocial interventions (excluding self-management) are recommended for the treatment of common mental health problems, follow the recommendations for intervention delivery set out in NICE guidelines CG911 and CG902, or the relevant NICE anxiety disorder guideline, unless otherwise stated. (NICE guideline recommendations for depression and anxiety disorders can also be cross-referenced in the NES (2015) Psychological Therapies Matrix³).

Self-management

Self-management programmes are recommended across all Chronic Health Problems for which there is an evidence-base. 'Self-management' denotes a low intensity intervention that aims to encourage

PROGRAMMES ARE OFTEN DELIVERED IN THE
COMMUNITY BUT CAN BE DELIVERED ACROSS
HEALTHCARE CONTEXTS BY A RANGE OF
HEALTHCARE PROFESSIONALS

awareness of and active patient participation in chronic condition management, including physical symptom and emotional management. Programmes are often delivered in the community but can be delivered across healthcare contexts by a range of healthcare professionals, including primary care clinicians with an understanding of psychological and physical disorders (e.g. nurse specialist, GP, dietician, physiotherapist, occupational therapist). Self-management programmes are largely homogenous albeit variably defined (e.g. self-management, self-regulation, psychoeducation, structured education programmes) with some idiosyncratic components for management of particular condition. Typically, programmes contain the following core components: condition-specific patient education, a cognitive-behavioural approach, 5 core self-regulation principles - goal setting, planning, self-monitoring, feedback and relapse prevention. Other psychosocial interventions such as relaxation, stress management and biofeedback are sometimes included within programmes but have not been reviewed separately here as evidence is limited and intervention content variably defined in trials.

Stand-alone interventions with a sole focus on information provision or patient education are distinct from self-management and should be incorporated within standard medical care. Despite some evidence of positive outcomes for some patients, stand-alone interventions do not confer substantial benefit to warrant separate recommendation (except where a sufficient evidence-base for self-management is lacking).

Service-level interventions

Collaborative care

NICE Guideline CG911 recommends collaborative care as part of a well-developed stepped-care approach for people with a Persistent Physical Symptoms with associated functional impairment and moderate to severe depression, particularly where there is evidence of a relationship between

STAND-ALONE INTERVENTIONS WITH A SOLE FOCUS ON INFORMATION PROVISION OR PATIENT EDUCATION ARE DISTINCT FROM SELF-MANAGEMENT AND SHOULD BE INCORPORATED WITHIN STANDARD MEDICAL CARE

depression and the health condition and/or an adequate response to initial treatment(s). Please refer to individual tables for condition specific recommendations.

As stated by NICE Guideline CG91 1, effective collaborative care comprises: case management supervised by and with support from a senior mental health professional, close collaboration between primary and secondary physical health services and specialist mental health services, a range of psychosocial interventions consistent with those recommended by NICE CG91, long-term co-ordination of care and follow up.

Service-level interventions with insufficient evidence for recommendation

There is currently insufficient evidence to recommend use of Psychiatric Liaison or Case Management as a service-level intervention for people with a Persistent Physical Symptoms and co-morbid depression¹.

THERE IS CURRENTLY INSUFFICIENT EVIDENCE
TO RECOMMEND USE OF PSYCHIATRIC
LIAISON OR CASE MANAGEMENT

ASTHMA

ASTHMA

ALL PEOPLE ACCESSING PRIMARY AND SECONDARY CARE SHOULD BE OFFERED SUPPORTED SELF-MANAGEMENT

SELF-MANAGEMENT FOR ASTHMA EMPHASISES THE IMPORTANCE OF RECOGNISING AND ACTING ON SYMPTOMS AND SIGNS OF DETERIORATION. ALL PEOPLE ACCESSING PRIMARY AND SECONDARY CARE SHOULD BE OFFERED SUPPORTED SELF-MANAGEMENT THAT INCORPORATES WRITTEN PERSONALISED ASTHMA ACTION PLANS (PAAPS)⁵.

Refer to the British guideline on the management of asthma (SIGN guideline 141)⁵ for a summary of the key components of a written PAAP that are associated with beneficial physical health outcomes. Note that duration, intensity and format of self-management delivery are variable in the evidence reviewed below⁵.

ASTHMA

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	Supported self-management incorporating written PAAPs. Improves markers of asthma control including reduction in asthmatic symptoms, days off work, emergency use of healthcare resources and 'as needed' medication.	A ^{4,5,6}	Supported self-management incorporating written PAAPs. Improves quality of life.	A ^{4,5}
				Improves depressed mood, anxiety.	B ⁴
Moderate to severe mental health problem	High intensity psychosocial intervention	Collaborative care. Improves general physical wellbeing and functioning.	B ¹	Individual or group CBT (with asthma education). Improves quality of life.	B ^{1,2,6}
				Collaborative care. Improves depressed mood.	B ¹

Insufficient evidence:

- Despite some evidence of positive benefit for some people, there is currently insufficient evidence to recommend use of telehealthcare interventions⁵.
- There is limited evidence that interventions specifically targeting psychological morbidity in difficult asthma are of benefit⁵.
- Lay-led self-management programmes for people with asthma are not recommended⁵.

CANCER

CANCER

RECOMMENDATIONS FOR PSYCHOSOCIAL INTERVENTIONS ARE MADE PAN-CANCER GIVEN THE LIMITED EVIDENCE-BASE FOR CANCER-SPECIFIC INTERVENTIONS AND LARGELY MIXED CANCER SAMPLES. PEOPLE WITH BREAST, GYNAECOLOGICAL OR GENITOURINARY CANCERS ARE MORE COMMONLY REPRESENTED IN RESEARCH TRIALS. IT SHOULD BE STRESSED THAT IMPROVEMENTS IN DEPRESSED MOOD ASSOCIATED WITH PSYCHOSOCIAL INTERVENTION DO NOT RESULT IN IMPROVEMENTS IN CANCER-RELATED OUTCOMES.

The Macmillan Cancer Support self-management work stream of the National Cancer Survivorship Initiative (NCSI) outlines that self-management is typically adjustment-focused (facilitation of transition to survivorship), problem-focused (e.g. enhancing coping skills for specific problems or symptoms, such as fatigue or relationship difficulties), or a combination of the two⁷. Self-management is recommended pan-cancer due to limited evidence for comparative efficacy within and between tumour groups.

SELF-MANAGEMENT IS RECOMMENDED PAN-CANCER DUE TO LIMITED EVIDENCE FOR COMPARATIVE EFFICACY WITHIN AND BETWEEN TUMOUR GROUP

CANCER

CANCER

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	Supported self-management, adjustment- or problem-focused. Improves physical activity and functioning, fatigue. Prostate cancer. Improves sexual dysfunction/satisfaction with sexual functioning, urinary control.	C ⁷	Supported self-management, adjustment- or problem-focused. Improves cancer-related psychological distress, depressed mood, emotional wellbeing, quality of life.	C ⁷
Moderate to severe mental health problem	Low intensity psychosocial intervention			Peer (self-help) support. Improves depressed mood.	B ¹
Moderate to severe mental health problem	High intensity psychosocial intervention	Collaborative care. Improves pain, fatigue, functioning and health.	B ^{1,8}	CBT for depression: a) Individual. Improves depressed mood. b) Group. Improves depressed mood. Collaborative care, e.g. 'Depression care for people with cancer' manualised, multicomponent collaborative care model. Improves depressed mood, anxiety, quality of life. Lung cancer. Collaborative care, e.g. Depression care for people with lung cancer. Improves depressed mood, anxiety, quality of life, role functioning.	B ^{1,2} B ^{1,2} B ^{1,8,9} B ¹⁰

CANCER

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- A recent systematic review of psychological interventions for people with cancer and depression cautions that there is a paucity of evidence for the use of stand-alone psychosocial interventions. There is some evidence that antidepressant medication alone or in combination with psychosocial intervention (e.g. in a collaborative care-type intervention) may be effective for this patient population⁹. To date, the relative effectiveness and potential harm of using standard drug and non-drug treatments provided to non-cancer patients for people with cancer is largely unknown⁹.

CARDIOVASCULAR DISEASE (CVD)

CARDIOVASCULAR DISEASE [CVD]

SELF-MANAGEMENT PROGRAMMES FOR CVD SHOULD BE PROVIDED WITHIN THE CONTEXT OF A COMPREHENSIVE CARDIAC REHABILITATION PROGRAMME. REHABILITATION COMPRISES A MEDICAL ASSESSMENT AND A MENU-BASED PROGRAMME WITH 6 COMPONENTS, NAMELY: LIFESTYLE, RISK FACTOR MANAGEMENT, CARDIO-PROTECTIVE DRUG THERAPY AND IMPLANTABLE DEVICES¹¹.

Psychosocial intervention is a key component of any programme, with a 'typical' programme including a minimum of one of the following: cognitive behavioural strategies, stress management or counselling, relaxation, energy conservation or pacing^{12, 13, 14}. Self-management should adopt a tailored approach whereby individual assessment of psychological need informs selection of psychosocial intervention(s)^{12, 13, 14}. Cardiac rehabilitation programmes following acute Myocardial Infarction should comprise an exercise component alongside a psychosocial intervention. Refer to NICE guideline CG167 for specific recommendations detailing safety precautions and patient populations for which exercise is contra-indicated for safety reasons¹⁷.

Recommendations for interventions are listed per condition:

- Cardiac arrhythmias in Coronary Heart Disease (CHD)
- Myocardial Infarction (MI) and MI with ST-segment elevation
- Stable Angina
- Unstable Angina and non-ST-segment-elevation myocardial infarction (NSTEMI)

CARDIAC REHABILITATION PROGRAMMES FOLLOWING ACUTE MYOCARDIAL INFARCTION SHOULD COMPRISE AN EXERCISE COMPONENT ALONGSIDE A PSYCHOSOCIAL INTERVENTION

CARDIOVASCULAR DISEASE (CVD)

Note that the range of CVD SIGN guidelines - Cardiac Rehabilitation 57^A, and Heart Disease 93-97^B are currently being updated. All are anticipated to include evidence on psychosocial interventions and should be referred to.

There is currently insufficient evidence upon which to base specific recommendations for people with heart failure¹⁵. Limited evidence shows some positive benefits in physical health outcomes and improvements in depression and anxiety from psychosocial intervention within rehabilitation programmes or from CBT approaches. It is possible that people with heart failure may benefit from psychosocial interventions delivered for other cardiovascular conditions. NICE guideline CG108 acknowledges an educational or psychosocial component should be included within supervised group exercise-based rehabilitation programmes for chronic heart failure¹⁵.

IT IS POSSIBLE THAT PEOPLE WITH
HEART FAILURE MAY BENEFIT FROM
PSYCHOSOCIAL INTERVENTIONS
DELIVERED FOR OTHER CARDIOVASCULAR
CONDITIONS

CARDIOVASCULAR DISEASE (CVD)

CARDIOVASCULAR DISEASE (CVD)

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome		
		What Intervention	Recommendation	What Intervention	Recommendation	
All levels of physical disorder severity	Low intensity psychosocial intervention	Self-management within cardiac rehabilitation programme.		Self-management within cardiac rehabilitation programme.		
		<p>Angina. Reduces angina frequency and severity, sublingual nitrate use, enhances health related quality of life (HRQL), physical functioning.</p> <p>MI and MI with ST-segment elevation. Reduces all-cause and cardiovascular mortality rates, and non-fatal MI recurrence.</p>	<p>B^{1,16}</p> <p>A^{13,17}</p>	<p>Angina. Improves self-efficacy to manage disease.</p> <p>MI and MI with ST-segment elevation. Improves anxiety, depressed mood.</p> <p>Cardiac arrhythmias in CHD. Improves depressed mood, anxiety, quality of life.</p> <p>Specific self-management programmes.</p>	<p>C¹⁶</p> <p>A^{1,13,17}</p> <p>B¹⁹</p>	
		a) Addition of partner >50% sessions. Improves disability, blood pressure, satisfaction with care & partner anxiety, disease/treatment knowledge.	B ¹⁸	<p>Angina. Angina Plan, nurse-delivered in primary care, comprising patient-held workbook with information on angina management, CV risk and psychoeducation about coping strategies, goal setting and pacing, and relaxation. Improves self-reported angina attacks, physical limitation.</p>	<p>Angina. Angina Plan, nurse-delivered in primary care, comprising patient-held workbook with information on angina management, CV risk and psychoeducation about coping strategies, goal setting and pacing, and relaxation. Improves depressed mood, anxiety, angina-related distress.</p> <p>MI. Home-based self-management, e.g., The Heart Manual, incorporating education, exercise & stress management, delivered post-MI by trained facilitator. Improves depressed mood, anxiety, increases illness control perceptions.</p>	B ¹⁴
		Specific self-management programmes.	B ¹⁴			B ¹³

CARDIOVASCULAR DISEASE (CVD)

CARDIOVASCULAR DISEASE (CVD)

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention			Chest pain of recent onset. Verbally assess any concerns including anxiety when the cause of the chest pain is unknown and provide information sheets. Improves anxiety, depressed mood.	B ²⁰
Mild to moderate mental health problem	Low intensity psychosocial intervention			Individual guided self-help based on CBT for depression improves depressed mood.	B ^{1,2}
Moderate to severe mental health problem	High intensity psychosocial intervention			CBT for depression: a) Individual. Improves depressed mood. b) Group. Improves depressed mood. c) Where there is low perceived social support, supplement a) or b) with SLT techniques to encourage social relationship development.	B ^{1,2} B ^{1,2} B ^{1,2}

Insufficient evidence:

- There is currently insufficient evidence to recommend use of individualised (menu-based) versus pre-planned, non-individualised programmes following MI¹³.

CHRONIC FATIGUE SYNDROME [CFS]

AN INDIVIDUALISED, PERSON-CENTRED MANAGEMENT PROGRAMME SHOULD BE OFFERED TO PEOPLE WITH CFS AS PART OF STANDARD MEDICAL CARE²¹.

The objectives of the programme should be to:

- Sustain or gradually extend, if possible, the person's physical, emotional and cognitive capacity
- Manage the physical and emotional impact of their symptoms

Psychosocial interventions for CFS should incorporate advice on relapse management for CFS as per NICE CG53 guideline²¹. Recommendations for psychosocial interventions for CFS are listed per CFS severity.

Rest periods are a component of all management programmes for CFS - for specific recommendations see NICE Guideline CG5321. Advice on sleep management (tailored advice on role/effect of sleep dysfunction, good sleep hygiene and introducing gradual changes to sleep patterns) and relaxation (guided visualisation or breathing techniques) is generally found to be helpful for people with CFS and may be incorporated within CBT interventions, however the evidence base for these specific components is very limited²³. Relaxation may be incorporated into rest periods for pain and sleep management²¹.

CHRONIC FATIGUE SYNDROME (CFS)

CHRONIC FATIGUE SYNDROME (CFS)

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of CFS severity	Self-management	Self-help booklet + individualised advice provision during primary care nurse consultation (booklet content; information about fatigue, self-monitoring and cognitive-behavioural approaches to address fatigue). Improves fatigue.	B ²²		
Mild to moderate CFS	Low intensity psychosocial intervention	<p>CBT adapted for CFS, 6 1 hour sessions. Improves fatigue, GP consultations, antidepressant usage.</p> <p>Counselling for depression/anxiety, 6 1 hour sessions. Improves fatigue, reduces GP consultations, antidepressant usage.</p>	<p>B²³</p> <p>B²³</p>	CBT adapted for CFS, 6 1 hour sessions. Improves anxiety, depressed mood, symptom attributions, social adjustment.	B ²³
Mild to moderate CFS	High intensity psychosocial intervention	<p>CBT adapted for CFS, up to 12-16 sessions. Reduces fatigue, improves physical function.</p> <p>Activity Management. Individually tailored and goal directed approach to symptom management promoting skills of activity grading and analysis to improve/maintain function and well-being. Improves fatigue, physical function.</p>	<p>A^{1, 21, 25, 26}</p> <p>C²¹</p>	<p>CBT adapted for CFS, up to 12-16 sessions. Improves depressed mood, anxiety, quality of life.</p> <p>Activity Management. Improves depressed mood, cognition.</p>	<p>A^{1, 21, 25, 26}</p> <p>C²¹</p>

CHRONIC FATIGUE SYNDROME (CFS)

CHRONIC FATIGUE SYNDROME (CFS)

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
Moderate to severe CFS	High intensity psychosocial intervention	Activity Management. Improves fatigue, physical function.	C ²¹	Activity Management. Improves depressed mood, cognition.	C ²¹

- Sleep management strategies should not include encouraging daytime sleeping/naps. People with CFS/ME should be advised that excessive sleep does not generally improve physical or mental functioning, and excessive periods of daytime sleep or frequent napping may further disrupt the sleep–wake cycle²¹.
- CBT has the clearest evidence of benefit for people with mild to moderate CFS, NICE guideline CG53 recommends individual delivery of CBT where possible²¹. If a full CBT programme is inappropriate or not available, components should be offered, either individually or more effectively in combination with: activity management strategies, sleep management, relaxation techniques. CBT should only be delivered by a healthcare professional with appropriate training in CBT and experience in CFS²¹.

Insufficient evidence:

- There is currently insufficient evidence to recommend use of Pacing/Adaptive Pacing Therapy in CFS self-management^{21, 25}.
- There is currently insufficient evidence to recommend use of CCBT for CFS²¹.

CHRONIC KIDNEY DISEASE (CKD)

CHRONIC KIDNEY DISEASE (CKD)

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	Self-management appropriate to CKD severity and cause, including a care plan detailing health-promoting activities (blood pressure, smoking cessation, exercise, diet and medicines). Extends time to, increases planned initiation of and choice of self-care of permanent vascular access for dialysis, decreases catheter use.	B ^{27,28}	Self-management appropriate to CKD severity and cause. Improves anxiety, behavioural health-related dysfunctions, health perceptions.	B ²⁷
		Renal Patient View (RPV). Improves control of medical care, GP-patient communication.	B ²⁸	Renal Patient View (RPV). Improves feelings of involvement in treatment and reassurance.	B ²⁸
Moderate to severe mental health problem	High intensity psychosocial intervention			Group-based CBT for depression, modified for CKD, 8 2 hour sessions over 8 weeks. Improves depressed mood, QoL.	B ¹

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

PULMONARY REHABILITATION IS AN INCREASINGLY POPULAR AND EFFECTIVE OPTION FOR PEOPLE WITH MODERATE TO SEVERE COPD, DEFINED AS A MRC DYSPNOEA SCORE GRADE 3 OR ABOVE¹, PEOPLE WHO CONSIDER THEMSELVES TO BE FUNCTIONALLY IMPAIRED AND PEOPLE RECENTLY HOSPITALISED FOR ACUTE COPD EXACERBATION²⁹.

Rehabilitation comprises individualised multicomponent, multidisciplinary interventions incorporating exercise programmes and education, nutritional, psychological and behavioural intervention²⁹. Individual programmes differ in the precise exercises used, duration and amount of home exercise, and have different referral criteria. Evidence for individual programme components that are exercise-based and effect physical health outcomes have not been separately reviewed. Pulmonary rehabilitation is not suitable for patients who are unable to walk, have unstable angina or who have suffered a recent myocardial infarction²⁹.

Most pulmonary rehabilitation programmes are provided in secondary care settings, usually on an outpatient basis, however community based programmes have recently been developed. Some evidence suggests rehabilitation is effective across settings however to date, the majority of studies have been performed in an outpatient setting²⁹.

SOME EVIDENCE SUGGESTS REHABILITATION IS EFFECTIVE ACROSS SETTINGS HOWEVER TO DATE, THE MAJORITY OF STUDIES HAVE BEEN PERFORMED IN AN OUTPATIENT SETTING

¹ Fletcher, C. M., Elmes, P. C., Fairbairn, A.S., & Wood, C. H. (1959). The significance of respiratory symptoms and the diagnosis of chronic bronchitis in a working population. *British Medical Journal*, 2(5147), 257-266.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	Self-management focusing on COPD exacerbation prevention through lifestyle adaption and exacerbation management skills. Improves medication usage.	B ²⁹	Moderate to severe COPD. Pulmonary Rehabilitation. Improves Quality of Life.	C ²⁹
		Moderate to severe COPD. Pulmonary Rehabilitation, outpatient setting, duration ranging from minimum of 6 weeks to maximum of 12 weeks (6-8 weekly, bi-weekly for patients in early stable phase of COPD). Improves functional exercise capacity, reduces dyspnoea. Reduces hospitalisation.	C ²⁹ B ²⁹		
Moderate to severe mental health problem	High intensity psychosocial intervention			Individual CBT for depression.	C ^{1,2}

CHRONIC PAIN

MULTIDISCIPLINARY BIOPSYCHOSOCIAL TREATMENT, COMMONLY REFERRED TO AS A MULTIDISCIPLINARY PAIN MANAGEMENT PROGRAMME (PMP) SHOULD BE PROVIDED FOR PEOPLE WITH CHRONIC PAIN DUE TO SUPERIOR MENTAL AND PHYSICAL HEALTH OUTCOMES TO UNIDISCIPLINARY TREATMENTS^{30, 31}.

A 'typical' PMP addresses one physical dimension and one or more psychological, social or occupational dimension, or, comprises a minimum of 3 of the following: psychotherapy, physiotherapy, relaxation techniques, medical treatment, patient education or vocational therapy³⁰. Psychosocial components typically implemented within a PMP include pain education, cognitive behavioural strategies, relaxation and biofeedback.

Recommendations for interventions are listed per chronic pain condition:

- Arthritis
- Chronic lower back pain (CLBP)
- Fibromyalgia
- Neuropathic pain following spinal cord injury
- Non-specific musculoskeletal pain or widespread chronic pain

A large proportion of the evidence base pertains to people with CLBP or Fibromyalgia. There is some evidence to suggest these patient populations experience greater benefits from PMPs than those with diverse origins of chronic pain diagnoses³⁰.

PSYCHOSOCIAL COMPONENTS
TYPICALLY IMPLEMENTED WITHIN A PMP
INCLUDE PAIN EDUCATION, COGNITIVE
BEHAVIOURAL STRATEGIES, RELAXATION
AND BIOFEEDBACK

CHRONIC PAIN

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	<p>PMP, typically up to 100 hours over 8 weeks.</p> <p>Non-specific musculoskeletal pain. Variety of outcomes; reduces pain, improves functioning and physical capacity, return to work rate and sick leave, use of healthcare system, use of medication, sleep quality.</p> <p>CLBP. As above.</p> <p>Fibromyalgia. Reduces pain, fatigue, disability, symptom impact.</p> <p>Neuropathic pain. Increases activity participation.</p>	<p>B³⁰</p> <p>B³¹</p> <p>B^{30,33}</p> <p>B³⁰</p>	<p>PMP, typically up to 100 hours over 8 weeks.</p> <p>Non-specific musculoskeletal pain. Variety of outcomes; improves depressed mood, quality of life, coping, pain behaviour.</p> <p>CLBP. As above.</p> <p>Fibromyalgia. Improves depressed mood, quality of life.</p> <p>Neuropathic pain following spinal cord injury. Improves anxiety.</p>	<p>B³⁰</p> <p>B³⁰</p> <p>B³¹</p> <p>B³⁰</p> <p>B³⁰</p>
		<p>Individual CBT delivered separately to PMP:-</p> <p>Various chronic pain conditions. Reduces pain, disability.</p> <p>Orofacial pain. Reduces pain, improves activity levels, pain-related disability.</p>	<p>A^{34,35}</p> <p>B³⁰</p>	<p>Individual CBT delivered separately to PMP:-</p> <p>Various chronic pain conditions. Improves depressed mood, catastrophizing.</p> <p>Orofacial pain. Improves depressed mood.</p> <p>CLBP. Improves depressed mood, adaptive coping.</p>	<p>A^{34,35}</p> <p>B³⁰</p> <p>B³⁰</p>

CHRONIC PAIN

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
Moderate to severe mental health problem	High intensity psychosocial intervention	CLBP. Reduces pain, disability, analgesic use, GP visits.	B ³⁰	Rheumatoid arthritis. Improves anxiety. Fibromyalgia: Improves depressed mood, catastrophizing. CBT at higher dosage (up to 16-20 sessions) preferred for greater effects on mental health outcomes.	B ³⁰
		Rheumatoid arthritis. Improves C-reactive protein, tender joint count.	B ³⁰		B ^{32, 36}
		Fibromyalgia. Improves pain, sleep, functional status, catastrophising. CBT at higher dosage (up to 16-20 sessions) preferred for greater effects on pain.	B ^{32, 36}		

- Cognitive or combined cognitive-behavioural approaches are preferential to stand-alone operant or behavioural therapies/psychological interventions with a primary behavioural focus for chronic pain conditions^{30,35,37}. Limited evidence suggests some positive effects of operant behavioural therapies on pain and depressed mood for people with CLBP³⁰ and healthcare seeking behaviour in people with fibromyalgia³⁷.

Insufficient evidence:

- There is currently insufficient evidence to recommend the use of stand-alone patient education, psychological interventions as mono-therapy or lower intensity combined physical and psychological therapies for CLBP³¹.
- Current evidence suggests that mindfulness-based stress reduction programmes (MBSR) and acceptance and commitment therapy (ACT) are not superior to CBT but may be good alternatives and are increasingly popular^{30,37}.

DIABETES, TYPE 1 AND TYPE 2

SELF-MANAGEMENT (ALSO KNOWN AS STRUCTURED DIABETES EDUCATION) IS AN INTEGRAL PART OF DIABETES CARE THAT AIMS TO IMPROVE OUTCOMES THROUGH ADDRESSING THE INDIVIDUAL'S HEALTH BELIEFS, OPTIMISING METABOLIC CONTROL, ADDRESSING CARDIOVASCULAR RISK FACTORS (HELPING TO REDUCE THE RISK OF COMPLICATIONS), FACILITATING BEHAVIOUR CHANGE (SUCH AS INCREASED PHYSICAL ACTIVITY), IMPROVING QUALITY OF LIFE AND REDUCING DEPRESSION.

An effective programme will also enhance the relationship between the person with diabetes and their healthcare professionals, thereby providing the basis of true partnership in diabetes management³⁸.

Self-management programmes should **include a psychosocial component** and cover all major aspects of diabetes self-care and be provided to people with diabetes and their family/carer(s) with annual reinforcement and review. Programmes should meet the criteria laid down by the Department of Health and Diabetes UK Patient Education Working Group, as recommended by NICE and SIGN guidelines^{38, 39, 43}.

- Evidence-based and theory-driven, tailored to individual need and encourage self-management attitudes in the family/carer(s) in addition to the patient
- Include a written structured curriculum with supporting materials
- Delivered by trained educators
- Quality assured and reviewed by trained independent assessors, with outcomes regularly audited

Psychosocial components of self-management programmes include: education, skills training, CBT, social support, relaxation, biofeedback, relapse prevention, stress management and relaxation.

PSYCHOSOCIAL COMPONENTS OF SELF-MANAGEMENT PROGRAMMES INCLUDE: EDUCATION, SKILLS TRAINING, CBT, SOCIAL SUPPORT, RELAXATION, BIOFEEDBACK, RELAPSE PREVENTION, STRESS MANAGEMENT, RELAXATION.

DIABETES, TYPE 1 AND TYPE 2

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	<p>Self-management, individual or group-delivered. Improves glycaemic control, HbA1c/GHb levels. Some evidence for improvement in reduced blood pressure, increased physical activity, improved foot care, body weight.</p> <p>Examples of self-management programmes ⁴³:-</p> <p>Dose Adjustment for Normal Eating (DAFNE) education self-management programme. Improves HbA1c levels, dietary freedom.</p> <p>Hypoglycaemia Anticipation, Awareness and Treatment Training (HAATT), HyPOS and Blood Glucose Awareness Training (BGAT). Improves hypoglycaemia rates and awareness.</p> <p>X-PERT programme. Improves HbA1c levels, weight loss.</p> <p>Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND). Improves weight loss.</p>	A ^{38, 39, 40, 41, 43, 44}	<p>Self-management programmes, individual or group-delivered. Improves depressed mood, anxiety, quality of life.</p>	A ^{39, 40, 41, 42, 43, 44, 45}

DIABETES, TYPE 1 AND TYPE 2

DIABETES, TYPE 1 AND TYPE 2

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
Mild to moderate mental health problem	Low intensity psychosocial intervention			Individual guided self-help based on CBT. Improves depressed mood.	C ^{1,2}
				Computerised CCBT (sleep hygiene advice in addition as required) for depression. Improves depressed mood, diabetes-specific emotional distress.	C ^{1,2,46}
Moderate to severe mental health problem	High intensity psychosocial intervention	Individual CBT. Improves glycaemic control, HbA1c levels.	A ^{1, 2, 41, 42, 43, 45}	Individual CBT. Improves depressed mood, psychological distress.	A ^{1, 2, 40, 41, 42, 43, 45, 46}
		Counselling. Improves glycaemic control, HbA1c levels.	B ^{42, 43, 47}	Group-based CBT for depression. Improves depressed mood, anxiety.	A ^{1, 2, 41, 42, 43, 44, 45}
		Collaborative care. Improves general physical wellbeing/functioning, glycaemic control	A ^{1, 46}	Counselling. Improves psychological distress.	B ^{42, 43, 47}
				Collaborative care. Improves depressed mood.	A ^{1, 46}

DIABETES, TYPE 1 AND TYPE 2

- CBT may be less effective in people with diabetes with complications^{43,47}.
- NICE CG15 guideline recommends that at the time of diagnosis and periodically thereafter, adults with Type 1 diabetes should be offered up-to-date information on the benefits of accessing local and national diabetes support groups. A 'support group' is a group of people with diabetes (typically unpaid and supported by national/local voluntary organisations) that provide support to themselves and others in their locality³⁹.
- NICE CG15 guideline states advice to adults with Type 1 diabetes should be provided by a range of multidisciplinary professionals with skills in diabetes care, working together with a coordinated approach. A common environment, e.g. diabetes centre, can be an important resource in allowing a diabetes multidisciplinary team to work and communicate efficiently while providing consistent advice (evidence rating C⁴⁰).

IRRITABLE BOWEL SYNDROME (IBS)

IRRITABLE BOWEL SYNDROME (IBS)

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	Patient information encouraging self-management of symptoms delivered by primary care clinician + self-care guidebook, including specific education about lifestyle, physical activity, diet and symptom-targeted medication. Improves IBS symptom severity, reduces primary care consultations and hospital visits.	B ⁴⁸	Patient information encouraging self-management of symptoms delivered by primary care clinician + self-care guidebook. Improves quality of life, treatment outcomes.	B ⁴⁸
		Refractory IBS or non-response to pharmacological treatment after 12 months. a) Individual or group CBT. Improves IBS symptoms. b) Psychodynamic interpersonal psychotherapy, with optional relaxation. Improves IBS symptoms, pain reduction	A ^{1, 2, 48, 49, 50} A ^{48, 49, 50}	Refractory IBS or non-response to pharmacological treatment after 12 months. a) Individual or group CBT. Improves quality of life. b) Psychodynamic interpersonal psychotherapy, with optional relaxation. Improves depressed mood, anxiety, quality of life.	B ^{1, 2, 49} B ^{48, 49}

Insufficient evidence:

- There is currently insufficient evidence to recommend use of relaxation or biofeedback for IBS⁴⁸.

Other evidence:

- Addressing psychosocial factors with an ongoing collaborative multi-disciplinary approach leads to improvement in the clinical outcomes, and while psychosocial factors do not cause IBS symptoms, they do influence the patient's response both to the condition and treatment⁴⁸.

MULTIPLE SCLEROSIS (MS)

MULTIPLE SCLEROSIS (MS)

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	Fatigue management/energy conservation. Improves fatigue.	B ⁵¹	Information provision about symptom management, possible development of cognitive difficulties, and support groups/services, delivered to patient and family/carer(s) by consultant neurologist with regular review. Improves sense of control, self-management, anxiety.	B ⁵¹
		Individual CBT. Improves fatigue, medication adherence	A ^{1, 2, 51, 52}	Individual CBT, mainly telephone delivered, improves depressed mood, distress, acceptance and coping beliefs.	A ^{1, 2, 52, 53}
Moderate to severe mental health problem	High intensity psychosocial intervention	a) If moderately impaired mobility (EDSScc score of ≥ 4), combine CBT with aerobic and moderate progressive resistance activity.	B ⁵¹		
		Mindfulness-based training. Improves fatigue.	B ⁵¹		

* N.B. A Cochrane review (2008)⁵⁴ suggested that cognitive behaviour approaches could also be beneficial in helping people adjust to and cope with Multiple Sclerosis. However, evidence is limited, further studies are recommended.

² See also Matrix Neurological Tables

OSTEOARTHRITIS

OSTEOARTHRITIS

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention			Self-management, 6 group sessions (e.g. 'Challenging Arthritis') + education booklet. Reduces anxiety, improves depressed mood, self-efficacy for pain and arthritis management.	A ⁵⁵
Mild to moderate mental health problem	Low intensity psychosocial intervention			Individual guided self-help based on CBT.	C ^{1,2}
Moderate to severe mental health problem	High intensity psychosocial intervention	Collaborative care. Improves pain reduction, increases likelihood of receiving psychological & pharmacological treatment.	B ¹	Individual CBT for depression. Collaborative care. Improves depression.	C ^{1,2} B ¹

RHEUMATOID ARTHRITIS

RHEUMATOID ARTHRITIS

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
All levels of physical disorder severity	Low intensity psychosocial intervention	Self-management (CBT-based or with joint protection focus). Improves pain control, hand pain, joint protection behaviour, physical activity, disability, mobility, use of assistive devices, reduces GP visits.	A ^{56, 57, 58}	Self-management (CBT-based or with joint protection focus). Improves depressed mood, anxiety, social functioning, coping, quality of life.	A ^{56,57,58}
		Individual CBT. Improves pain, disability.	A ^{1, 2, 57, 58}	Individual CBT. Improves depressed mood, anxiety, coping, social functioning.	A ^{1, 2,57,58}
Moderate to severe mental health problem	High intensity psychosocial intervention	Collaborative care. Improves pain reduction, increased likelihood of receiving psychological & pharmacological treatment.	B ¹	Collaborative care. Improves depression.	B ¹

OVERWEIGHT/OBESITY

MULTICOMPONENT INTERVENTIONS THAT ADDRESS THREE LIFESTYLE AREAS RELATED TO OVERWEIGHT AND OBESITY – DIET, PHYSICAL ACTIVITY AND PSYCHOLOGICAL APPROACHES TO BEHAVIOURAL CHANGE (BEHAVIOURAL/ COGNITIVE-BEHAVIOURAL) – ARE MORE EFFECTIVE THAN SINGLE COMPONENT INTERVENTIONS. COMPREHENSIVE INTERVENTIONS – THAT IS, INTERVENTIONS THAT ADDRESS ALL THREE AREAS – ARE MORE EFFECTIVE THAN THOSE THAT ADDRESS ONLY ONE OR TWO OF THEM ⁵⁹⁻⁶⁵.

Lifestyle approaches are well suited to delivery in primary health care, with referral to more specialist services (e.g. including dietitians, psychologists, physiotherapists) required for the most complex patients. Comprehensive weight loss interventions can be provided in individual or group sessions. Group interventions have been found to be equally as effective as individual approaches, and offer the advantage of increased clinical capacity. Clinicians/interventionists should receive specialist training in behavioural strategies to support weight management interventions. Electronically delivered weight loss programmes (including by telephone) that include personalised feedback from a trained interventionist can be prescribed for weight loss but may result in smaller weight loss than face-to-face interventions ⁵⁹⁻⁶⁵.

Some commercial-based programs that provide a comprehensive lifestyle intervention can be prescribed as an option for weight loss provided there is peer-reviewed published evidence of their safety and efficacy ⁶⁵.

Individuals should be well informed and supported in changing health behaviours, and be assisted to manage overweight and obesity in partnership with one or more healthcare professionals. Interventions should be individualised, and supported by self-management principles and regular review by a healthcare professional. Family/significant other support can also help to maximise treatment outcome. Influences on health behaviours (e.g. social, physical and psychological factors) should be directly considered and addressed when planning and delivering interventions with individuals ^(62, 63). Across all formats of delivery, weight loss maintenance should be considered a main goal ^{63, 65}.

Those with mental illness, including severe and enduring presentations, should not immediately be excluded from weight management programmes, as evidence suggests such individuals can do as well as those with no or less intense/severe difficulties. Tailoring of treatments is required, with access to mental health specialists recommended to support engagement ⁶⁶⁻⁶⁹.

PSYCHOSOCIAL COMPONENTS TYPICALLY IMPLEMENTED WITHIN A COMPREHENSIVE WEIGHT MANAGEMENT PROGRAMME INCLUDE:

- SELF MONITORING OF BEHAVIOUR AND PROGRESS
- STIMULUS CONTROL (WHERE THE PATIENT IS TAUGHT HOW TO RECOGNISE AND AVOID TRIGGERS THAT PROMPT UNPLANNED EATING)
- COGNITIVE RESTRUCTURING (MODIFYING UNHELPFUL THOUGHTS/THINKING PATTERNS)
- GOAL SETTING
- PROBLEM SOLVING
- ENSURING SOCIAL SUPPORT
- ASSERTIVENESS TRAINING
- SLOWING THE RATE OF EATING
- REINFORCEMENT OF CHANGES
- RELAPSE PREVENTION
- STRATEGIES FOR DEALING WITH WEIGHT REGAIN

OVERWEIGHT/OBESITY

Overweight/obese clients who meet diagnostic criteria for Binge Eating Disorder (BED) can be seen within weight management programmes; however, additional psychological support would be recommended prior to, or alongside lifestyle intervention. BED treatment should be in line with Matrix recommendations from within the adult eating disorders section. Note: engagement with a lifestyle programme to encourage weight loss is contraindicated where an individual meets the criteria for Bulimia Nervosa or other recognised eating disorders.

Alongside lifestyle interventions, **bariatric (weight loss) surgery** may be offered to clients meeting eligibility criteria. Psychological assessment is recommended as best practice and should be part of the wider assessment for patients' suitability for surgery⁶². Multicomponent lifestyle advice should be part of the bariatric surgery patient pathway, pre and post surgery, to enhance surgical outcome⁶⁰. Clinicians working in bariatric services/teams should therefore receive appropriate specialist training relevant to the surgical intervention(s) being offered, plus training in behavioural strategies to support weight management and surgical interventions.

Insufficient Evidence:

- More research is required in the evaluation of the effectiveness of comprehensive lifestyle programmes for overweight or obese adults with a formal learning disability diagnosis.
- Apart from behavioural/cognitive-behavioural approaches, the strength of evidence for the primary adoption of alternative psychological interventions (e.g. motivational interviewing, mindfulness, ACT) remains low.
- There is little evidence for the use of inpatient weight management approaches.

OBESITY / WEIGHT LOSS INTERVENTIONS

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
Overweight (BMI>25)* And Obesity (BMI>30)*	Low intensity psychosocial intervention as part of a comprehensive lifestyle programme.	Comprehensive lifestyle programme of up to 12 months (or more) that assists participants in adhering to a lower calorie diet and in increasing physical activity through the use of behavioural / cognitive behavioural strategies.	A ⁵⁹⁻⁶⁵	Comprehensive lifestyle programme of up to 12 months (or more) that assists participants in adhering to a lower calorie diet and in increasing physical activity through the use of behavioural / cognitive behavioural strategies.	A ⁵⁹⁻⁶⁵
		More frequent support should be offered initially (e.g. a minimum of 3 months of fortnightly sessions), followed by monthly maintenance/ monitoring sessions. Provided in either a group or individual basis.		More frequent support should be offered initially (e.g. a minimum of 3 months of fortnightly sessions), followed by monthly maintenance/ monitoring sessions. Provided in either a group or individual basis.	
		Programmes should aim for sustained modest weight loss (5-10 kg or 5-10% at one year).		Programmes should aim for sustained modest weight loss (5-10 kg or 5-10% at one year).	
		Include a self-management approach in weight management programmes.	C ⁶³	Quality of life, self-esteem and depression: may improve, even with small amounts of weight loss.	C ^{63,73}

* Lower BMI cut-offs appear appropriate to define obesity-related risk in higher risk groups such as South Asians. Until specific cut-offs are validated, South Asian, Chinese and Japanese individuals may be considered overweight at BMI >23 and obese at BMI >27.5 (4).

OBESITY / WEIGHT LOSS INTERVENTIONS

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
		<p>Electronically delivered weight loss programs may result in smaller weight loss than face-to-face interventions.</p> <p>For those who meet bariatric surgery eligibility criteria, low intensity behavioural lifestyle interventions should be integrated in to the pre and post operative care pathway.</p> <p>Weight loss: Weight management programmes have been found to be clinically effective for those who engage in treatment and complete the programme in both primary and secondary care.</p> <p>Weight Maintenance: Behavioural interventions show small but significant benefits on weight loss maintenance for up to 12-24 months, with increasing evidence for maintenance of weight loss beyond 2 years. Frequency of contact does appear to influence outcomes.</p>	<p>B⁶⁵</p> <p>C^{62, 63}</p> <p>B⁶⁹</p> <p>B^{63, 65, 71, 72} General overweight/ obese population A⁷⁰</p> <p>With co-morbid T2 Diabetes</p>	<p>Depression with co-morbid T2 Diabetes: Moderate weight loss in patients with mild to moderate symptoms of depression is associated with improvements, not worsening, in mood. Frequency of contact may have an influence on weight and mood outcomes.</p>	<p>B⁷⁴</p>

OBESITY / WEIGHT LOSS INTERVENTIONS

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
		<p>Mortality: Moderate intentional weight loss of around 5 kg or more in overweight and obese adults with a history of diabetes is associated with lowered all-cause mortality. Intentional weight loss of between 5 kg to 10 kg in obese women with some obesity-related illness is associated with lowered cancer-related mortality and lowered diabetes-related mortality.</p> <p>CVD: Modest sustained weight loss reduced cardiovascular risk factors.</p> <p>Diabetes: Adults with prediabetes or diabetes can be advised that modest sustained weight loss can result in prevention, delayed progression or improved control of type 2 diabetes.</p> <p>Asthma: Weight loss of more than 10kg in obese patients with asthma is associated with improved lung function.</p> <p>Kidney Disease & Sleep Apnoea: Improvements associated with a 5% weight loss.</p>	<p>B⁶²</p> <p>A^{63,65}</p> <p>A⁶³</p> <p>B⁶²</p> <p>B⁶³</p>		

OVERWEIGHT/OBESITY

OBESITY / WEIGHT LOSS INTERVENTIONS

Level of Severity	Intensity	Physical Health Outcome		Mental Health Outcome	
		What Intervention	Recommendation	What Intervention	Recommendation
		<p>Musculoskeletal problems, gastro-oesophageal reflux or urinary incontinence: Weight loss of 5% or more may improve symptoms.</p>	C ⁶³		

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